

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04091

4988

CERTIFICATE OF DEATH

Reg. Dist. No.

166

1. PLACE OF DEATH a. COUNTY Garrett				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 3 mo.		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park, Md. X		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppett Nursing Home				d. STREET ADDRESS /					
3. NAME OF DECEASED (Type or print)		First Mary	Middle McRobie	Last Brooks	4. DATE OF DEATH April 16, 1957	Month April	Doy 16	Year 1957	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1880	9. AGE (In years lost birthday) 76 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. DAYS 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Swanton, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis M. McRobie				14. MOTHER'S MAIDEN NAME Lucy McRobie					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Lee Lucas, Bayard, W. Va.			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Vascula Accident DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) ADDRESS (Street, city or town, state)	(County)	(State)		
21. I certify that I attended the deceased from April 15, 1957 to April 16, 1957 , that I last saw the deceased alive on April 15, 1957 , and that death occurred at 8:45 P.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>E.J. Baumgartner</i>	M.D.		DATE SIGNED 4/10/57						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 20, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Deer Park			22d. LOCATION (City, town, or county) Deer Park, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Accusation</i>			ADDRESS Bolden Funeral Home Oakland, Md.		24a. REC'D. BY REGISTRAR 4/20/57				
					24b. REGISTRAR'S SIGNATURE <i>Julia Rowan</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MEXICO CITY, MEXICO

APR 30 1957

RECEIVED
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

040926
076

4'89 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEER PARK		b. COUNTY GARRETT				
c. LENGTH OF STAY IN lb 60 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO DEER PARK				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS /				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First SAMUEL	Middle S.	Last BROWNING			
4. DATE OF DEATH	Month APRIL	Day 13	Year 19 57			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 4, 1870			
9. AGE (In years last birthday) 87 yrs.	10. KIND OF BUSINESS OR INDUSTRY RETIRED PAINTER	11. BIRTHPLACE (State or foreign country) GREENGLADE, MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ARCHIBALD BROWNING	14. MOTHER'S MAIDEN NAME KATHRYN FRAZEE					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT MR. VAN BROWNING	Address DEER PARK MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure INTERVAL BETWEEN ONSET AND DEATH 3 days						
422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
Artioschistic Cardiovascular Disease 10 years						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour 10 a.m.	Month, Day, Year Apr 13 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Oakland	(County) Maryland	(State)
21. I certify that I attended the deceased from April 10, 1957 , to Apr 13, 1957 , that I last saw the deceased alive on April 13, 1957 , and that death occurred at 1126A M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 77 Oak Street		
ACTUAL SIGNATURE Herbert H. Leighton M.D.				DATE SIGNED April 15, 1957		
PHYSICIAN'S NAME (Type) Herbert H. Leighton				Oakland, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/16/57	22c. NAME OF CEMETERY OR CREMATORIAL DEER PARK	22d. LOCATION (City, town, or county) DEER PARK	(State) MD.		
23. FUNERAL DIRECTOR'S SIGNATURE Bellenton				24a. REC'D. BY REGISTRAR 1957 Debra Brown	24b. REGISTRAR'S SIGNATURE L.R.	
VS A15 (4) 1SM 9/55						

WYOMING STATE DEPARTMENT OF HEALTH - BILLINGS, WY

CERTIFICATE OF DEATH

DECEASED'S NAME	AGE	SEX	CAUSE OF DEATH
EDWARD R. HARRIS	60	M	HEART DISEASE
ADDRESS	DATE OF DEATH	TIME OF DEATH	PLACE OF DEATH
101 E. 2nd Street	APR 8 1957	10:00 A.M.	HOSPITAL
NAME AND ADDRESS OF PHYSICIAN			
DR. JAMES C. COOPER 101 E. 2nd Street			
NAME AND ADDRESS OF FUNERAL DIRECTOR			
HARRIS FUNERAL HOME 101 E. 2nd Street			
NAME AND ADDRESS OF PERSON FILING CERTIFICATE			
EDWARD R. HARRIS 101 E. 2nd Street			

BUREAU V. S.

APR 8 1957

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. After this bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04094

CERTIFICATE OF DEATH

4090

Reg. Dist. No.

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		MARYLAND LENGTH OF STAY (In this place) Lifetime		STATE Maryland COUNTY Garrett CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Selbysport STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) Inez (Middle) Mae (Last) Friend			4. DATE OF DEATH (Month) (Day) (Year) 4 4 1957		
S. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 4/16/1878	9. AGE last birthday 78 yrs.	IF UNDER 1 YEAR Months Deys Hours Min. 0 0 0 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper			10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Winfield Scott Friend			14. MOTHER'S MAIDEN NAME Eva Ellen Laughrey		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Miss. Agnes Frazee, Selbysport	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 450.0 IMMEDIATE CAUSE (A) <i>Arterio Sclerosis</i> ANTECEDENT CAUSE(S) DUE TO: _____ DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO: _____ (C) <i>Rheumatic Deformans</i> <i>Senility</i> INTERVAL BETWEEN ONSET AND DEATH <i>several years</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from..... 1957, 19..... to..... Apr. 4, 1957, that I last saw the deceased alive on..... Mar. 30, 1957, and that death occurred at..... 11:30 AM from the causes and on the date stated above. SIGNATURE <i>H. B. Messmore</i> M.D. ADDRESS (Street, city, town, state) <i>10 Addison Ave.</i> DATE SIGNED <i>1957</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/7/1957		NAME OF CEMETERY OR CREMATORIALy Friendsville	
24. REC'D BY REGISTRAR DATE April 6, 1957		REGISTRAR'S SIGNATURE Mrs Ruth Frentz		25. FUNERAL DIRECTOR'S SIGNATURE Jack S. Friend, Friendsville Md.	
ADDRESS					

DEPARTMENT OF STATE - CHARTERED BY THE GOVERNMENT OF

CHARTERED BY THE GOVERNMENT OF

CHARTERED BY
THE GOVERNMENT OF

CHARTERED BY THE GOVERNMENT OF

CHARTERED BY THE GOVERNMENT OF

BUREAU U. S.

1957 Sept 9 1957

REVIEWED
SEARCHED
INDEXED
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FILED

W.M. WILSON
W.M. WILSON
W.M. WILSON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04095
166

4091

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY GARRETT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY GARRETT		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Oakland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Oakland Xo		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Catherine	Middle	Last Georg	4. DATE OF DEATH	Month April	Day 28	Year 19 57
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Mar. 30, 1878	9. AGE (In years lost 79 yrs.) 79 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	Day 0	Year 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Accident, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Christian Bietzel			14. MOTHER'S MAIDEN NAME Susan Bowman					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Fred Glotfelty, Oakland, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arterio sclerotic C-V Disease</i> INTERVAL BETWEEN ONSET AND DEATH 422.1 DUE TO <i>10 years</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) _____		(c) _____				
DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>12 hour</u> , 19 <u>46</u> , to <u>28 April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>26 April</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>A. E. Mance</i>		ADDRESS (Street, city or town, state) <i>Oakland Md</i> DATE SIGNED <i>28 April 1957</i>						
PHYSICIAN'S NAME (Type) A. E. Mance, M. D.		Oakland, Maryland 28 April, 1957						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 1, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Accident		22d. LOCATION (City, town, or county) Accident (State) MD.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Reedman</i>		ADDRESS Bolden Funeral Home Oakland, Md.		24a. REC'D BY REGISTRAR 5/1/57		24b. REGISTRAR'S SIGNATURE <i>Julio Rowan</i>		

CERTIFICATE OF DEATH

REGISTRATION NO.	NAME
SEX	AGE
DEATH DATE	TIME
CAUSE OF DEATH	DIAGNOSIS
DEATH CERTIFIED	APPROVED
RECEIVED	RECEIVED
BUREAU X. S.	
MAY 3 1957	
RECEIVED	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. After this bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04097

4092 CERTIFICATE OF DEATH

Item 13 Film G213 4-12-57 et

Reg. Dist. No. 172

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR endive town) TOWN	GARRETT KITZMILLER	MARYLAND	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	MARYLAND KITZMILLER	COUNTY GARRETT
LENGTH OF STAY (in this place)			(If rural give location)		
1/2 yrs.			OAK STREET		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS		
OAK STREET			OAK STREET		
3. NAME OF DECEASED (First) SAMUEL (Middle) ALONZO (Last) HADDIX			4. DATE OF DEATH APRIL 2, 1957		
5. SEX MALE	6. COLOR OR WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH FEB. 22, 1869	9. AGE last birthday 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during working life, even if retired) MINER			10b. KIND OF BUSINESS COAL MINES	11. BIRTHPLACE (State or foreign country) Grafton, W.Va.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Adam Haddix			14. MOTHER'S MAIDEN NAME JULIA ANN KERN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unk.) NO			16. SOCIAL SECURITY NO. NONE	17. INFORMANT & ADDRESS Mrs. Annie Haddix, Kitzmiller, Md.	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) Acute Myocarditis ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Coronary Heart Disease GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (C)			4 days 52 yrs.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Pneumonia					
19e. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan. 1, 1957</u> , to <u>April 2, 1957</u> , that I last saw the deceased alive on <u>April 2, 1957</u> , and that death occurred at <u>10:45 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>H. H. Colquhoun</u> ADDRESS (Street, city, town, state) <u>Kitzmiller, Md.</u> DATE SIGNED <u>April 2-57</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/5/57		NAME OF CEMETERY OR CREMATORIUM 1.000.F. Cemetery	
24. REC'D BY REGISTRAR DATE <u>4/14/57</u>		REGISTRAR'S SIGNATURE <u>Barrett</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Blaine, W.Va.	

BY TELETYPE TO THE UNITED STATES ATTORNEY'S OFFICE
OF THE DISTRICT OF COLUMBIA

CHARGE TO STANDING CHARGE

RECORDED IN THE OFFICE OF THE ATTORNEY GENERAL

APR 8 1957

RECEIVED

BUREAU V. A.

APR 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G214 4-18-57 et

4093

CERTIFICATE OF DEATH

04099
166

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY		GARRETT			
OAKLAND				X2		OAKLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
WEEKS NURSING HOME									
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
FRANKLIN				KIMMELL	APRIL	1	1957		
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost, birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
MALE		WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	FEB-22-1886	77 ¹¹ yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
RETIRED		FARMER		THAYERVILLE		U.S.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address					
WILLIAM KIMMELL		JENNY BOWSER.		CLAUDE KIMMELL CUMBERLAND, MD.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH			
(If yes, give war or dates of service)									
151X		Carcinoma of Stomach		DUE TO		17.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) Arteriosclerotic heart disease		(c)					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		420.0				19. WAS AUTOPSY PERFORMED?			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 1-1, 1957, to 7-6, 1957, that I last saw the deceased alive on 4-6, 1957, and that death occurred at 12:20 A.M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE		M.D.		58 2nd st. Oakl. - 4-8-77				DATE SIGNED	
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)	
BURIAL		APRIL-9-1957		THAYERVILLE CEMETERY		THAYERVILLE		MD	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Emory Bolden		OAKLAND MD		DATE 4/9/57		Julia Rowley			

CERTIFICATE OF DEATH

BUREAU Y.

APR 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04101
1066

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN lb RURAL GORMANIA X0	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS ROUTE #1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EMMA		First EMMA	Middle MAY
4. DATE OF DEATH Month APRIL Day 18 Year 1957		Last MARTIN	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/2/96
9. AGE (In years lost birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) BARTON, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME FRANK KYLE		14. MOTHER'S MAIDEN NAME ANNA MAY LEE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT CARL C. ATHEY? Box 1 35, Cumberland, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Arterio sclerosis CVD		Address 509 1/2	
422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 60 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6 Apr , 19 57 , to 4/18/18 , 19 57 , that I last saw the deceased alive on 4/18/18 , 19 57 , and that death occurred at 9:05 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Oakland Md	
ACTUAL SIGNATURE Andrew E. Mance PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M. D.		DATE SIGNED 18 Apr 18	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/21/57	22c. NAME OF CEMETERY OR CREMATORIAL Laural Hill	22d. LOCATION (City, town, or county) MOSCOW, (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Reederson		24a. REC'D BY REGISTRAR Julia O'Dowd DATE 4/19/57	24b. REGISTRAR'S SIGNATURE KR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be forwarded to the funeral director. Page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 2

APR 30 1957

RECEIVED

CERTIFICATE OF DEATH

4995

Reg. Dist. No.....

INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **48 hours** after death.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	Garrett Friendsville	MARYLAND LENGTH OF STAY (in this place)	STATE W. Va. COUNTY Mongalia CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	3 years		
3. NAME OF DECEASED (Type or Print)		(First) Malissie	(Middle) Rachel
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH June 30, 1879
9. AGE last birthday 77 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	11. BIRTHPLACE (State or foreign country) West Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Scott Dobbins	14. MOTHER'S MAIDEN NAME Katherine Moore		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		Coronary occlusion Arteriosclerotic Heart Disease Thromboembolitis left leg - 2 months	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1954, 19, to April 16, 1957, that I last saw the deceased alive on April 16, 1957, and that death occurred at 12 P.M. from the causes and on the date stated above.			
SIGNATURE <i>Harold Diamond</i>		ADDRESS (Street, city, town, state) <i>R. D. Markleyburg Apartments</i>	DATE SIGNED <i>5/7/57</i>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 4/24/57	NAME OF CEMETERY OR CREMATORIUM Hallack Cemetery	LOCATION (City, town, or county) Nr. Morgantown, W. Va.
24. REC'D BY REGISTRAR Mrs. Ruth Frantz	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE <i>Jack N. Friend Friendsville</i>	
DATE April 22, 1957		ADDRESS	

BUREAU A. S.

APR 24 1957

REGELIV E

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4996 CERTIFICATE OF DEATH

Reg. Dist. No. 186

04103

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 3 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> X2 Crellin	
3. NAME OF DECEASED (Type or print) Oscar		First Adam	Middle Shaffer
4. DATE OF DEATH 4 19 1885	Last Shaffer	Month 4	Day 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2-1-1885
8. AGE (In years last birthday) 72 yrs.	9. IF UNDER 1 YEAR Months 0	10. IF UNDER 24 HRS. Days 0	11. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner	10b. KIND OF BUSINESS OR INDUSTRY Coal	11. BIRTHPLACE (State or foreign country) West Virginia	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Shaffer, Daniel		14. MOTHER'S MAIDEN NAME Saucer, Ellen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 163 X		16. SOCIAL SECURITY NO. 213-10-3753	
17. INFORMANT "Gladys Graham Shaffer (Wife) Box 42, Crellin, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 163 X		INTERVAL BETWEEN ONSET AND DEATH 6 days	
DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma Lung Bilateral		6 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) OAKLAND		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/22/45 to 19 apr 57 , 1945, to 1945, 1957, that I last saw the deceased alive on 19 apr 57 , 1945, and that death occurred on 4/4/45 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Andrew E. Mance		ADDRESS (Street, city or town, state) Oakland, Md.	
PHYSICIAN'S NAME (Type) ANDREW E. MANCE M.D.		DATE SIGNED 20 apr 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/57	
22c. NAME OF CEMETERY OR CREMATORIAL Oakland		22d. LOCATION (City, town, or county) Oakland	
23. FUNERAL DIRECTOR'S SIGNATURE Bolden		ADDRESS Bolden Funeral Home Oakland, Md.	
24a. REC'D BY REGISTRAR 4/22/57		24b. REGISTRAR'S SIGNATURE Beth G. Powers	

100 CERTIFICATE OF DEATH

RECEIVED	SEARCHED	INDEXED	SERIALIZED	FILED
APR 30 1957				
BUREAU V. S.				
RECEIVED				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4097

CERTIFICATE OF DEATH

05215

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park,		c. LENGTH OF STAY IN lb 16 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park,				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Missouri Belle Speicher		First	Middle	Last	4. DATE OF DEATH April 29, 1957	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1866	9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Nine			14. MOTHER'S MAIDEN NAME Arthezia Shaw					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. —		17. INFORMANT Harry Speicher		Address Deer Park, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Brachopneumonia 15 days								
(b) DUE TO Arteriosclerosis 15 years		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 491X								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Feb. 13, 1948 , to April 29, 1957 , that I last saw the deceased alive on April 29, 1957 , and that death occurred at 9:30 P.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE Andrew E. Mance		ADDRESS (Street, city or town, state) Oakland DATE SIGNED 40 April 1957						
PHYSICIAN'S NAME (Type) A. E. Mance, M. D.		OAKLAND, MARYLAND 30 April 1957						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/2/1957		22c. NAME OF CEMETERY OR CREMATORIUM Paradise Cemetery		22d. LOCATION (City, town, or county) (State) near Deer Park, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton		ADDRESS Oakland, Md. 24a. REC'D. BY REGISTRAR 1957 Julia Rowan 24b. REGISTRAR'S SIGNATURE pp						

MISSOURI STATE DEPARTMENT OF HIGHER EDUCATION

CERTIFICATE OF DEATH

1954

RECEIVED

BUREAU X.

MAY 10 1957

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4998 CERTIFICATE OF DEATH

04106

Reg. Dist. No. 17E

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY GARRETT CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN RURAL - VINDEX		MARYLAND LENGTH OF STAY (in this place) 8 yrs		STATE MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Vindex	
HOSPITAL OR INSTITUTION OR STREET ADDRESS West Vindex			STREET ADDRESS West Vindex (If rural give location)		
3. NAME OF DECEASED (First) SANDRA (Middle) DARLENE (Last) STEWART			4. DATE OF DEATH APRIL 5, 1957		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Bingle	8. DATE OF BIRTH Feb. 9, 1949	9. AGE last birthday 8 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10b. KIND OF BUSINESS OR INDUSTRY 2nd. Grade	11. BIRTHPLACE (State or foreign country) West Vindex, Md.	
13. FATHER'S NAME WILLIAM ALBERT STEWART			14. MOTHER'S MAIDEN NAME MARCELLA KATHERN BROWN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input checked="" type="checkbox"/> No unk.) No (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. NONE		
17. INFORMANT & ADDRESS WM. A. STEWART, Star Route Kitzmiller, Md.			18. MEDICAL CERTIFICATION Cardio - Vasculas Nervous Disease with nodular edema Chronic Hepatitis		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 581.0 IMMEDIATE CAUSE (A) Cardio - Vasculas Nervous Disease ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) giving rise to the above cause STATING UNDERLYING CAUSE LAST. DUE TO (C) Chronic Hepatitis			INTERVAL BETWEEN ONSET AND DEATH 6 days. 2 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) Kitzmiller, Md. (State) W. Va.	
21d. TIME OF INJURY (Month) Apr (Day) 5 (Year) 1957 (Hour) 6:10 AM		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 1954 to April 5, 1957 , that I last saw the deceased alive on April 5, 1957 , and that death occurred at 6:10 AM , from the causes and on the date stated above. SIGNATURE John Culverell M.D. ADDRESS (Street, city, town, state) Kitzmiller, Md. DATE SIGNED April 8, 1957					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/8/57		NAME OF CEMETERY OR CREMATORIUM I.O.O.F. Cemetery	
24. REC'D BY REGISTRAR DATE 4/8/57		REGISTRAR'S SIGNATURE Alv Barwick		LOCATION (City, town, or county) Elk Garden, W. Va. (State) W. Va.	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Otha F. Sharpless		Blaine, W. Va.			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04107
166

4099

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician and completely filled in by the medical director. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY GARRETT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X 2 OAKLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS 17 SECOND STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CLARA	Middle A.	Last STUCK	4. DATE OF DEATH Month APRIL	Day 10,	Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9/29/1888	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) POINT OF ROCKS, MD.,		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE BROWN				14. MOTHER'S MAIDEN NAME ADALINE WRIGHT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT MR. GEORGE STUCK, 7 SECOND STREET-OAKLAND, MD.,		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease INTERVAL BETWEEN ONSET AND DEATH 3 yrs 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis 10 yrs DUE TO (c) diabetes mellitus 10 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Oakland Md	(County) Oakland	(State) MD.
21. I certify that I attended the deceased from app. , 19 50 , to April 10 , 19 57 , that I last saw the deceased alive on April 11 , 19 57 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Andrew E. Mance</i>	ADDRESS (Street, city or town, state) Oakland, Maryland						DATE SIGNED 11 Apr 57
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D.,	OAKLAND, MARYLAND						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF APRIL 13, 1957	22c. NAME OF CEMETERY OR CREMATORIAL HOME POINT OF ROCK			22d. LOCATION (City, town, or county) POINT OF ROCK (State) MD.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. M. Mance</i>	BOLDEN MINERAL HOME ADDRESS OAKLAND, MD.	24a. REC'D BY REGISTRAR DATE 4/12/57			24b. REGISTRAR'S SIGNATURE <i>Jesse M. Mance</i>		

CERTIFICATE OF DEATH

MD 1957

BUREAU V. S.

APR 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04108

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEAR GRANTSVILLE		c. LENGTH OF STAY IN 1b —	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XI GRANTSVILLE	
d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LATRY MARVIN WARICK		4. DATE OF DEATH Last APRIL Month 29 Year 1957	5. SEX M
6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 28 1952
9. AGE (in years last birthday) 4 yrs.		10. IF UNDER 1 YEAR Months — Days —	11. IF UNDER 24 MRS. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MEYERSDALE Comm Hosp		12. CITIZEN OF WHAT COUNTRY? 21.5.14.	
13. FATHER'S NAME MARVIN WARICK		14. MOTHER'S MAIDEN NAME MARY DURST	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mawin Warick, Grantsville, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CRUSHING & INJURY LEFT OCCIPITAL PORTION OF SKULL			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) —			
DUE TO (c) —			
INTERVAL BETWEEN ONSET AND DEATH —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH fall out of car		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Run over by right front wheel	
20c. TIME OF INJURY Month, Day, Year Hour 3 p.m. 4/29 1957		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) farm
		20f. (City or town) Baltimore	20g. (County) Baltimore
		20h. (State) Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE E. L. Baumgartner		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E. L. BAUMGARTNER M.D.		DATE SIGNED 4/29/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 1, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL METHODIST CEM		22d. LOCATION (City, town, or county) NEW GERMANY-GARRETT CO MD	
23. FUNERAL DIRECTOR'S SIGNATURE Donald J. Newman, Grantsville Md		24a. REC'D BY REGISTRAR DATE MAY 6 1957	
		24b. REGISTRAR'S SIGNATURE Deborah	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

V.S. A15ME(S)
5M 9/55

BUREAU V. S

MAY 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4101

CERTIFICATE OF DEATH

Reg. Dist. No.

06169

1. PLACE OF DEATH a. COUNTY GARRETT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY GRANT		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND.		c. LENGTH OF STAY IN 1b 2 Mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BAYARD 85X-3		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First CHARLES	Middle A.	Last WILLIAMS	4. DATE OF DEATH APRIL 15	Month Month	Day Day	Year Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 11/1/82	9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COAL MINER Retired		10b. KIND OF BUSINESS OR INDUSTRY Soft COAL		11. BIRTHPLACE (State or foreign country) MARYLAND, U.S.A.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME ANDREW WILLIAMS				14. MOTHER'S MAIDEN NAME MARTHA FREELAND				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 232-03-2228		17. INFORMANT Mrs. Lela Williams		Address Ba yard, W. Va.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO 177X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Carcinoma prostate DUE TO 2 year (c)								
INTERVAL BETWEEN ONSET AND DEATH 6 months								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Oakland	(County) Maryland	(State) W. Va.
21. I certify that I attended the deceased from August 8, 1956 , to April 15, 1957 , that I last saw the deceased alive on April 14, 1957 , and that death occurred at 7:45 AM , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) Oakland, Maryland								
DATE SIGNED 4/16/57								
ACTUAL SIGNATURE Joseph Alvarez M.D.								
PHYSICIAN'S NAME (Type) JOSEPH ALVAREZ M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/17/1957		22c. NAME OF CEMETERY OR CREMATORIUM Bayard Cemetery		22d. LOCATION (City, town, or county) Bayard, Grant Co., W. Va.		
(State) W. Va.								
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Daugherty		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE 4/17/57		24b. REGISTRAR'S SIGNATURE J. P. Brown		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The physician may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SS

CERTIFICATE OF DEATH

BUREAU V. S.

APR 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4102

CERTIFICATE OF DEATH

04/11/68

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XI ACCIDENT	
3. NAME OF DECEASED (Type or print) WILHELM		First WILHELM	Middle ZINKAN
4. DATE OF DEATH APRIL 14		Last ZINKAN	Month Day Year 1957
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3/31/77
8. AGE (In years lost birthday) 80 yrs.		9. IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY own farm	11. BIRTHPLACE (State or foreign country) Accident, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME HENRY ZINKAN		14. MOTHER'S MAIDEN NAME ELLEN MILLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Waldo Zinkan, Accident, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. Anterio sclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 9, 1954 to Apr 14, 1957 , that I last saw the deceased alive on APRIL 14, 1957 , and that death occurred at 5:55 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 3520 Eudist DATE SIGNED 4/15/57	
ACTUAL SIGNATURE E. I. Baumgartner		PHYSICIAN'S NAME (Type) E. I. BAUMGARTNER, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/17/57	22c. NAME OF CEMETERY OR CREMATORIAL St Paul's	22d. LOCATION (City, town, or county) Accident, Garrett Co., Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Donald J. Newman		ADDRESS Grantsville, Md.	24a. REC'D BY REGISTRAR DATE 4/16/57
		24b. REGISTRAR'S SIGNATURE Dee Howey	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REGISTRATION NUMBER
MATERIAL NUMBER
NAME

andrew & trent

BUREAU V. S.

APR 18 1957

RECEIVED